PHARMACY PLUS

A DEMONSTRATION PROGRAM UNDER SECTION 1115

STATE OF RHODE ISLAND

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NOTE: This application template is pending approval from the Office of Management and Budget and is considered draft.

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Pharmacy Plus Application

The State of RHODE ISLAND, Department of DEPARTMENT OF HUMAN SERVICES proposes an 1115 Demonstration Proposal entitled RHODE ISLAND RX+ or RIx + which will extend pharmacy services and related medical management interventions to RHODE ISLAND SENIORS AND CERTAIN PERSONS WITH CHRONIC AND POTENTIALLY DISABLING CONDITIONS at or below 2OO percent of the federal poverty level (FPL).

I. GENERAL DESCRIPTION

This demonstration will extend pharmacy coverage to individuals in a fashion that furthers public, private, and individual fiscal responsibility. The demonstration is designed to assist low-income Medicare beneficiaries who have high drug costs. The demonstration offers assistance by 1) providing access to prescription drugs and related services, 2) assisting individuals with high premiums/cost sharing for private coverage for prescription drugs, or 3) providing wraparound pharmaceutical coverage to bring private sources of pharmacy coverage up to the level of the Pharmacy Plus benefit coverage. The proposed program also ensures access to primary care to complement and assist in the management of the enrollee's pharmacy services. An important element in Pharmacy Plus is the use of competitive private sector approaches, such as benefit management, to provide more cost effective, modern prescription drug benefits in Medicaid

Individuals eligible for the proposed program include those who are Medicare beneficiaries, who have not been determined eligible for full Medicaid benefits, whether or not they are eligible for Medicare Savings programs under Medicaid (which pay Medicare premiums, and in some cases, Medicare cost sharing expenses, e.g., QMBs and SLMBs) and/or people with a disability. Cost sharing - in the form of premiums, co-payments, coinsurance, and deductibles - for the expansion population may differ from cost-sharing requirements for the regular Medicaid program.

The budget neutrality ceiling will be a single aggregate budget amount for the demonstration period. The state will be accountable for both expenditure and enrollment growth in the population subject to the budget neutrality ceiling which includes both the demonstration enrollees and the budget neutrality impacted population.

The demonstration will operate for **5** years, beginning approximately **MARCH 1, 2003.**

II. ASSURANCES

Each of the following items are checked to indicate an assurance:

A. X **Primary care coordination**. The demonstration includes a mechanism to direct demonstration enrollees who access services to sources of primary health services. Such primary care will include, but is not limited to, medical management related to prescription and non-prescription pharmaceutical products. The state assures that those individuals who do not have access to primary care as Medicare beneficiaries will have access to primary care services. More information about this requirement is provided in Section V, Part I.

B. X **Benefits, access to services, and cost sharing.** The benefits and rights of the State Plan eligibility groups, except for restriction to choice of providers as provided through a section 1115(a)(1) waiver of 1902(a)(23) through Pharmacy Plus, are as provided for in the state's Medicaid State Plan, Title 42 of the Code of Federal Regulations, and Title XIX of the Social Security Act.

C. X **Budget neutrality.** The federal cost of services provided during the demonstration will be no more than 100 percent of the expected federal cost to provide Medicaid services under current law without the demonstration. The benefits and rights of the State Plan eligibility groups are not altered by this demonstration. An Excel budget worksheet is provided that includes the budget projections, with and without waiver cost estimates, information about covered individuals, trend rate information, and a narrative description of the calculations. More information about this requirement is provided in Section VI.

D. X **Public notice requirements**. The demonstration complies with public notice requirements as published in the Federal Register, Vol. 59, No. 186 dated September 29, 1994 (Document number 94-23960) and Centers for Medicare & Medicaid Service (CMS) requirements regarding Native American Tribe consultation. Provide information about this assurance in Appendix 1.

III. STATE-ONLY FUNDED PHARMACY PROGRAMS

The following information is provided for current state-only funded pharmacy programs (Check all that apply):

A. _____ State Program Entirely Subsumed Into Demonstration. A state-only funded pharmacy program named _____ currently exists, and it will be subsumed by the demonstration (Complete this section for each state program that will be entirely subsumed into the demonstration program. Provide as an attachment a description of the state-only funded program, including enrollee cost-sharing, benefit limits, wraparound coverage, and any other pertinent features).

1. Income level ceiling. The income level ceiling for participation is_____ percent FPL.

2. Program eligibility characteristics. In addition to income ceiling, the program eligibility parameters have the following further specifications:
    a. _____ age group (describe):
    c. _____ condition specifications (describe):
    d. _____ other specifications (describe):

3. Benefit coverage scope. The scope of benefits covered under the program is
    a. _____ broad (such as the Medicaid package)
    b. _____ narrow (such as limited to drugs to treat specific health conditions)
    c. _____ other (describe):

3. _____ There are enrollee financial contributions, which include:
    a. _____ premiums (describe):
    b. _____ deductibles (describe):
    c. _____ co-payments/coinsurance (describe):
    d. _____ other (describe):

5. _____This proposed demonstration will be an expansion of coverage compared to the current state pharmacy program through:
    a. _____expanding the scope of coverage (e.g., type or number of prescriptions available)
    b. _____expanding the pharmacy services available (e.g., by providing a pharmacy or nurse consultant who will provide additional management services)
    c. _____expanding the type of individuals eligible
    d. _____expanding the number of individuals eligible
    e. _____expanding funding to assist with premiums and cost sharing
    f. _____other (describe)

6. Annual cost. Currently the program expenditures are $_____ on an annual basis for the program.

7. Enrollment figures. Currently there are _____ enrollees in the program.

8. _____ This proposed demonstration will not be an expansion of coverage compared to the current state pharmacy program, but enactment of pharmacy cost-saving measures in Medicaid will assist to achieve budget neutrality.

B. X State Programs Partially Subsumed Into Demonstration. **Three** state-only funded pharmacy programs named **RI PHARMACY ASSISTANCE PROGRAM FOR THE ELDERLY (RIPAE), COMMUNITY MEDICAL ASSISTANCE PROGRAM (CMAP) AND GENERAL PUBLIC ASSISTANCE (GPA)** currently exist, and will be **partially** subsumed by the demonstration (Complete this section for each state program that will be partially subsumed into the demonstration program. Provide as an attachment a description of the state-only funded program, including enrollee cost-sharing, benefit limits, wraparound coverage, and any other pertinent features).

RHODE ISLAND PHARMACY ASSISTANCE PROGRAM FOR THE ELDERLY

2. Income level ceiling. The income level ceiling for participation is between **356 and 420** percent FPL **depending on family size.**

2. Program eligibility characteristics. In addition to income ceiling, the program eligibility parameters have the following further specifications:
   a. **X** age group (describe): **RI residents age 65 and older**
   b. _____ condition specifications (describe):
   X other specifications (describe): **Income disregard for out-of-pocket medical expenses. No benefit unless or until person is without any form of prescription coverage – i.e., uninsured or prescription benefit has been exhausted. There is no limit on assets.**

3. Benefit coverage scope. The scope of benefits covered under the program is
   a. _____ broad (such as the Medicaid package)
   b. _____ narrow (such as limited to drugs to treat specific health conditions)
   c. **X** other (describe): **Several classes of prescription drug medications are not covered.**

4. **X** There are enrollee financial contributions, which include:
   a. _____ premiums (describe):
   b. _____ deductibles (describe):
   c. **X** co-payments/coinsurance (describe): **Co-payments vary by income level. Level I (up to 187% of FPL) enrollee pays 40% of cost per Rx filled; Level 2 (187% up to 233% of FPL) enrollee pays 70% of cost per Rx filled; and Level 3 (233% to 420% of FPL) enrollee pays 85% of cost per Rx filled.**
   d. _____ other (describe):

5. **X** This proposed demonstration will be an expansion of coverage compared to the current state pharmacy program through **but only for individuals with income at or below 200% of the FPL**:

    a. **X** expanding the scope of coverage (e.g., type or number of prescriptions available)
    b. **X** expanding the pharmacy services available (e.g., by providing a pharmacy or nurse consultant who will provide additional management services)
    c. _____expanding the type of individuals eligible
    d. _____expanding the number of individuals eligible
    e. **X** expanding funding to assist with premiums and cost sharing
    f. _____other (describe)

6. Annual cost. Currently the program expenditures are $ **8.2 million** on an annual basis for the program. **Approximate expenditures for population to be covered under the waiver is $7.7 million. (Both figures are after rebates** .

7. Enrollment figures. Currently there are **39,000** enrollees in the program; **approximately, 34,000 of current RIPAE enrollees will qualify for RIx + waiver benefits.**

8.____ This proposed demonstration will not be an expansion of coverage compared to the current state pharmacy program, but enactment of pharmacy cost-saving measures in Medicaid will assist to achieve budget neutrality.

GENERAL PULBIC ASSISTANCE PROGRAM

3. Income level ceiling. The income level ceiling for participation is **below 100** percent FPL. **Specifically, the income limit is $327 per month for an individual and $449 per month for a family.**

2. Program eligibility characteristics. In addition to income ceiling, the program eligibility parameters have the following further specifications:
    a. **X** age group (describe): **19 up to age 65.**
    b. **X** condition specifications (describe): **RI residents who are impoverished and incapacitated due to a health condition and would be deemed disabled were it not for the therapeutic drugs provided through the program's prescription benefit**
    c. **X** other specifications (describe): **There is a $400 asset limit that is applied against income.**

3. Benefit coverage scope. The scope of benefits covered under the program is
    a. _____ broad (such as the Medicaid package)

b. _____ narrow (such as limited to drugs to treat specific health conditions)
c. **X** other (describe): **The program provides a narrow benefit that covers prescription medications for a limited range of high cost chronic, and in some instances acute conditions. The program also provides primary care services and cash assistance.**

4._____ There are enrollee financial contributions, which include:
a. _____ premiums (describe):
b. _____ deductibles (describe):
c. _____ co-payments/coinsurance (describe):
d. _____ other (describe): **GPA recipients pay the full cost for prescription medications that are not covered by the program.**

5. **X** This proposed demonstration will be an expansion of coverage compared to the current state pharmacy program through:

a. **X** expanding the scope of coverage (e.g., type or number of prescriptions available)
b. **X** expanding the pharmacy services available (e.g., by providing a pharmacy or nurse consultant who will provide additional management services)
c. _____expanding the type of individuals eligible
d. _____expanding the number of individuals eligible
e. **X** expanding funding to assist with premiums and cost sharing
f. _____other (describe)

6. Annual cost. Currently the program expenditures are **$1,016,500** on an annual basis for the program. **In FY 2002, expenditures for the GPA prescription drug benefit were slightly over $900,000; the remainder was spent on physician services and cash grants for recipients.**

7. Enrollment figures. Currently there are **1,100** enrollees in the program.

8. N/A This proposed demonstration will not be an expansion of coverage compared to the current state pharmacy program, but enactment of pharmacy cost-saving measures in Medicaid will assist to achieve budget neutrality.

COMMUNITY MEDICAL ASSISTANCE PROGRAM

1. Income level ceiling. The income level ceiling for participation is **not set at a specific** percent FPL. **The RI Community Medical Health Centers determine eligibility on the basis of need by evaluating an individual's financial circumstances relative to the cost of the medications necessary to avoid institutionalization. Only those CMAP enrollees with income at or below 200% FPL will be eligible for waiver**

prescription medication coverage, however.

2. Program eligibility characteristics. In addition to income ceiling, the program eligibility parameters have the following further specifications:
   a. **X** age group (describe): **19 and older**
   b. **X** condition specifications (describe): **RI residents who have a serious, chronic mental health condition that, without therapeutic drug treatment, requires institutionalization or an institutional level of care.**
   c. _____ other specifications (describe):

3. Benefit coverage scope. The scope of benefits covered under the program is
   a. _____ broad (such as the Medicaid package)
   b. **X** narrow (such as limited to drugs to treat specific health conditions**)** **Covers psychotropic medications only.**
   c. _____other (describe):

4.____ There are enrollee financial contributions, which include:
   e. _____ premiums (describe):
   f. _____ deductibles (describe):
   g. _____ co-payments/coinsurance (describe):
   h. _____ other (describe): **CMAP participants must pay full cost for any medications not included as part of benefit.**

5. **X** This proposed demonstration will be an expansion of coverage compared to the current state pharmacy program through:

   b. **X** expanding the scope of coverage (e.g., type or number of prescriptions available)
   g. **X** expanding the pharmacy services available (e.g., by providing a pharmacy or nurse consultant who will provide additional management services)
   h. _____expanding the type of individuals eligible
   i. _____expanding the number of individuals eligible
   j. **X** expanding funding to assist with premiums and cost sharing
   k. _____other (describe)

6. Annual cost. Currently the program expenditures are **$3.6 million** on an annual basis for the **program's existing caseload of 1,600 participants. As data on income is not collected on a routine basis, it is not possible to state precisely annual program costs for the CMAP population that will be eligible for the waiver. Program administrators indicate that most current participants have income below 200% FPL.**

7. Enrollment figures. **The number of CMAP participants varies from month to month,**

but generally does not exceed 1,600. The entities responsible for determining eligibility, the RI Community Mental Health Centers, report that not all eligible individuals participate in the CMAP on a regular basis. The Rhode Island Department of Mental Health, Retardation and Hospitals (MHRH), the state agency that administers CMAP, estimates that about 1,900 of the program's participants will be eligible to enroll each year for prescription coverage under the waiver.

8. _____ This proposed demonstration will not be an expansion of coverage compared to the current state pharmacy program, but enactment of pharmacy cost-saving measures in Medicaid will assist to achieve budget neutrality.

ADDITIONAL INFORMATION ABOUT THE WAIVER COVERAGE GROUPS IS LOCATED IN SUPPLEMENT A.

IV. PROGRAM ELEMENTS

Population to Whom Eligibility is Expanded under this Demonstration

Individuals eligible for Pharmacy Plus include those who are Medicare beneficiaries, whether or not they are eligible for Medicare Savings programs under Medicaid (which pay Medicare premiums, and in some cases, Medicare cost sharing expenses, e.g., QMBs and SLMBs) and/or people with a disability, who have not been determined eligible for full Medicaid benefits. States may also propose to extend the pharmacy benefit to persons age 65 and older who are not Medicare beneficiaries and to persons under age 65 who receive Social Security Disability Insurance (SSI) but not Medicare (i.e., are in the 24-month waiting period for Medicare) or who have a disability as defined by the Supplemental Security Income program.

A. Eligibility Groups

1. X Aged individuals (65 and older)
   a. X Medicare beneficiaries
   b. X non-Medicare beneficiaries
   c. X individuals with private pharmacy coverage (describe): **Seniors with Medicare + Choice, Medigap, retiree and commercial plans will be eligible to enroll, but only for wraparound coverage.**
   d. other (describe):

2. X Individuals with Disabilities (ages **19** to **64 in GPA and over 19 in CMAP**)
   a. _____ Medicare beneficiaries
   b. X individuals with private pharmacy coverage (describe): **CMAP and GPA enrollees who have other prescription coverage will be eligible to enroll, but only for wraparound coverage.**
   c. _____ Social Security Disability Insurance (SSDI) beneficiaries in 24-month waiting period for Medicare
   d. _____ lost SSDI due to earnings (disabling condition continues)
   e. _____ could receive Supplemental Security Income if federal eligibility rules used (for 209(b) states)
   f. X other (describe): **CMAP participants, including the approximately 2/3 that are Medicare beneficiaries, who have chronic mental health conditions that require an institutional level of care in the absence of therapeutic drug treatment. GPA recipients who are incapacitated and, in many cases, awaiting a disability determination due to a chronic/acute and potentially disabling condition requiring prescription medication treatment.**

3. Other (describe):

B. Income Groups

1. **Two hundred** percent of FPL is the ceiling for the demonstration expansion group for aged individuals. NOTE, the CMS proposed ceiling is 200 percent FPL or below. The current Medicaid State Plan coverage percentage level for this group is **100** percent FPL (if group varies within the aged population, describe):

2. **Two hundred** percent of FPL is the ceiling for the demonstration expansion group for individuals with disabilities. NOTE, the CMS proposed ceiling is 200 percent FPL or below. The current Medicaid State Plan coverage percentage level for this group is **100** percent FPL (if group varies within the disabled population, describe):

C. Income Adjustments

1. **X** Income is adjusted
   a. in the same manner as in Medicaid for the group
   b. **X** in a different manner than in Medicaid (describe): **In addition to the standard Medicaid income exclusions and disregards, the State will disregard up to $1,500 a year in health insurance premium costs. This includes premiums paid for Medigap, Medicare + Choice, and employer-sponsored plans as well as commercial products purchased in the individual/group market. (SEE SUPPLEMENT B FOR FURTHER DETAILS.)**
2. _____ income is not adjusted

D. Assets Test

1._____an assets test will apply. It is
   a._____the same as the Medicaid assets test for the_group
   b._____different from the Medicaid assets test (describe)
2. **X** no assets test will apply **(SEE SUPPLEMENT B FOR FURTHER INFORMATION.)**

E. Enrollment Limit

1. **40,000** is the total number of demonstration enrollees permitted to enroll in the demonstration (describe how and why this number was chosen): **The State estimates that approximately 37,000 RI residents will be enrolled in the waiver by year 5 if current trends in Rx utilization, prescription costs, population growth and private health insurance coverage continue as predicted: 34,000 seniors, 1,100 GPA recipients and 1,900 CMAP participants. The State has elected to cap enrollment at 40,000, about 8% above the expected level, and for two reasons: (1) although enrollment could be increased by as much as an additional 5% above the cap before jeopardizing budget neutrality, limiting enrollment will ensure that full Medicaid benefits for the aged, blind and disabled is not at serious risk; and (2) the 8% enrollment cushion is sufficient to accommodate any short-term spikes in the number of eligible individuals**

that arise as a result of unanticipated declines in health care access/resources for the populations covered.

1. _____There will not be an enrollment ceiling
2. _____The state will not utilize an enrollment ceiling initially, but will track budget neutrality and plans to utilize the enrollment ceiling at a later point in time (describe):
3. **X** **Other: The State would like to reserve the option to exceed the enrollment cap if utilization trends are significantly below estimated levels.**

F. Pharmacy Benefits Package

Consistent with the pharmaceutical focus of Pharmacy Plus, the demonstration does **not** include non-pharmacy benefit changes (such as reducing Medicaid coverage for other services or reducing coverage for existing Medicaid populations). The challenge posed in Pharmacy Plus is to improve cost-effectiveness through maintaining the health status of individuals and managing medications more effectively. The drug rebate provisions of section 1927 of the Social Security Act are triggered by state payments for prescription drugs under the plan by operation of the Pharmacy Plus demonstration project, and thus, rebates may be collected from manufacturers for drugs provided to the expansion population. The federal share of rebates paid will be returned to the federal government.

The following describes the proposed benefits to be included in this demonstration (check all that apply):

1. **X** demonstration eligibility will be extended to those who have pharmacy coverage through private health insurance, and enrollees will receive:
   a. **X** assistance with private health insurance cost sharing (see Section V.H.): **For enrollees with private Rx coverage, the State will pay the difference, if any, between private Rx co-pays and waiver co-pays.**
   b. X wraparound services (See Section V.H.): **Waiver enrollees be able to fill prescriptions for medications that are not included under a private plan, as long as the medications are covered by Medicaid. (SEE SUPPLEMENT FOR FURTHER DETAIL.)**
   c. _____ other (describe and See Section V.H.):

2. **X** enrollees without private health insurance pharmacy coverage will receive prescription drug coverage as follows:
   a. **X** the benefit package will be the same as in the Medicaid State Plan for non-demonstration enrollees
   b. _____ the benefit package will differ from that in the Medicaid State Plan for non-demonstration enrollees in that:
      i. certain classes of drugs will be excluded or limited (describe):
      ii. the number or frequency of prescriptions covered will be less than in the

Medicaid State Plan for non-demonstration enrollees (describe):

iii. drugs covered only for specified conditions (describe):

iv. other (describe):

c. _____ other (describe):

3. the state limits benefits to a financial ceiling per _____ of $ _____ (describe):

4. _____ other (describe):

G. Pharmacy Benefit Management

Pharmacy Plus programs may use private-sector benefit management approaches consistent with the requirements of section 1927(d) (such as pharmacy benefit managers, preferred drug lists, prior authorization, pharmacist consultation, provider education, disease state management, and variable enrollee cost sharing) in order to more efficiently and effectively manage pharmaceutical costs and ensure that spending stays within the federal budget neutrality cap. These benefit management approaches may also be extended to some or all of the existing Medicaid population, and the resulting savings used to achieve budget neutrality. The demonstration will include pharmacy benefit management as follows:

1. **X** pharmacy benefit manager (describe):
   a. **X** this is currently used in the state Medicaid program, will continue to be operated similarly, and it is currently under contract with **multiple contractors. (SEE SUPPLEMENT B FOR DETAILS).**
   b. ____this is not used in the Medicaid program and will be used only for demonstration enrollees.
   c. ____this will be introduced with the demonstration and will apply to the entire Medicaid population (demonstration and non-demonstration)
   d. ____ other (describe):

2. **X** prior authorization (describe): **Individuals enrolled in the Rhode Island Healthy Pharmacy Waiver will be subject to the same prior authorization requirements as its Medicaid beneficiaries. To ensure proper healthcare, the DHS has conducted a Prior Authorization Program for years. (SEE SUPPLEMENT B FOR DETAILS).**
   a. **X** this is currently used in the state Medicaid program
   b. _____ this is not used in the Medicaid program and will be used only for demonstration enrollees
   c. _____ this will be introduced with the demonstration and will apply to the entire Medicaid population (demonstration and non-demonstration)

3. _____formulary or formulary exclusions consistent with Section 1927(d)(4) of the Social Security Act (describe):

a. _____this is currently used in the state Medicaid program
b. _____this is not used in the Medicaid program and will be used only for demonstration enrollees
c. _____this will be introduced as a State Plan Amendment with the demonstration and will apply to the entire Medicaid population (demonstration and non-demonstration)

4. _____ other (describe)

H. Coordination with Other Sources of Pharmacy Coverage – Private, State, and Medicare Plus Choice Plans

Coordination with and non-duplication of existing sources of health insurance is an important feature of the Pharmacy Plus Demonstration. It maintains the position of Medicaid as payer of last resort and provides an incentive for enrollees to continue to participate in private coverage, thus supporting the maximization of participation in private insurance, employer sponsored insurance, COBRA, retiree health insurance plans, Medigap plans and Medicare+Choice plans. Pharmacy Plus is designed to work effectively with other Medicare pharmacy options.

The coordination and support can be:

- Actuarially equivalent payments to private carriers (or to enrollees) made on behalf of Pharmacy Plus in lieu of direct coverage of pharmaceuticals under the Pharmacy Plus program; and/or
- In the form of providing wraparound pharmaceutical coverage to bring private sources of pharmacy coverage up to the level of the Pharmacy Plus benefit coverage.
  In this demonstration, the following approaches will apply (check all items that apply – Also, See Section V.F.1.):

1.**X** Subsidies/cost sharing assistance for private health insurance coverage will be provided under the demonstration, and is clarified in the submitted budget neutrality information. The process for providing the subsidy will be described in the operational protocol and CMS approval of the payment methodology and amount will be requested. Subsidies/incentives will be provided for enrollees to maintain coverage of the following:

a. _____ Private health insurance coverage (describe):
b. _____ Medigap (describe):
c. _____Medicare-endorsed pharmacy discount cards. The demonstration includes financial contribution towards the drugs purchased using the card (describe coordination with the card and contribution to the purchase)
d. **X** other (describe) **Applicants with income above 150% of FPL who have another form of Rx coverage will have the option to accept: (1) a $25 per month incentive that could be used to subsidize their health insurance premium in lieu of waiver benefits for a year; or (2) wraparound coverage. (SEE SUPPLEMENT FOR FURTHER INFORMATION.)**

2. **X** Pharmacy coverage will be provided to enhance other sources of pharmacy coverage, such as state programs, Medicare+Choice and private sources of coverage in a wraparound fashion in order to encourage participation in existing public and private sources of care (describe): **All enrollees with income up to 150% FPL, who have another form of Rx coverage will be provided with wraparound services. State will serve as secondary payer (see TPL below). As explained above, individuals with alternative Rx coverage and income above 150% FPL will also receive wraparound coverage if they opt for waiver coverage rather than the $25 per month incentive payment. Wraparound services available under the waiver will cover any prescriptions included under the Medicaid benefit that are excluded by an enrollee's other pharmacy coverage as well as payment of any differences in cost-sharing up to the Medicaid rate.**

3._____ Other (describe):

4. **X** Third Party Liability will be collected in the demonstration in the following manner (describe): **The State will utilize the system now in place for Medicaid to collect TPL. (SEE SUPPLEMENT B FOR ADDITIONAL DETAILS.)**

5. _____ Third Party Liability will not be collected in the demonstration because

a. _____ individuals with other pharmacy coverage are excluded
b. _____ other (describe):

6. _____ Coordination with other sources of coverage is not part of this demonstration because: _____

I. Primary Care Coverage and Related Medical Management (check all that apply)

The demonstration includes a mechanism to ensure that demonstration enrollees have access to primary care health services that will assist with medical management related to pharmacy products prescribed. These aspects of the demonstration will be implemented as follows:

1. **X** Demonstration enrollees who have a source of coverage for primary care (for example, Medicare coverage) will use their primary care providers to coordinate the pharmacy benefit (describe): **State law requires health care providers authorized to prescribe medications to provide patients with at least a minimal level of primary care services on a regular basis (e.g., physical exams, medication management consults, etc.). The majority of waiver enrollees already have some form of primary care coverage that includes medication management services (i.e., seniors and CMAP participants through Medicare, private plans and the Community Mental Health**

Centers and GPA through the existing program). In addition, RI licensed pharmacists who enter into collaborative practice agreements with physicians are authorization to provide therapeutic drug management. Accordingly, the State is confident that coordination of waiver pharmacy benefits will not: (1) require a significant expansion in access to primary care or medication management services; nor (2) impose an undue financial and/or administrative burden on enrollees and providers.

2. **X** Demonstration enrollees who do not have a source of primary care coverage will receive primary care services through the demonstration as follows:
   a. _____ A primary care benefit the same as that in Medicaid will be provided (describe):
   b. **X** A limited primary care benefit of **one visit to a primary care provider for routine medical services including medication coordination or two therapeutic drug management consultations per year with an appropriately qualified license pharmacist. The State also plans to provide primary care referrals -- See 3 (i.), (iii.), and (v.) below as well.**

3. _____ Primary care access will be ensured by connecting clients to primary care sources for care in the community (e.g., FQHCs/RHCs, Ryan White providers, Indian Health Services facilities, Veterans' Affairs clinics, etc.) If the above is checked, the following must be checked and completed:
   i. **X** state to work with Primary Care Associations to facilitate access to services
   ii. _____ geographic breakdown of FQHC services provided that demonstrates adequate capacity to serve the demonstration population
   iii. **X** pharmacy and state written materials for demonstration participants include names, locations, and phone numbers of community sources of primary care
   iv. _____oral counseling by pharmacists to include information on accessing primary care
   v. **X** Other (describe) **The Rhode Island Departments of Elderly Affairs and Human Services are developing a plan to refer applicant's eligible for comprehensive Veteran's primary care and pharmacy services to the appropriate participating providers and organizations.**

4. _____ Other (describe):

J. Premiums and Cost Sharing Information (check all that apply)

Flexibility to include cost sharing, similar to that found in employer sponsored private health insurance coverage, is an important feature of the Pharmacy Plus Demonstration. Enrollee cost sharing can be in the form of annual or monthly premium assessments, per-prescription co-payment requirements, coinsurance, deductibles, and coverage limits. Cost sharing helps the state

to operate a budget neutral program and encourages personal responsibility and involvement of enrollees in their health care. States may require that cost sharing be met by demonstration participants (i.e., those in the expansion population) in order to receive benefits under the program. Cost sharing may be used to reduce program costs by requiring enrollee payments. To encourage the use of generic drugs and to discourage the use of costly drugs for which there are lower cost alternatives, Pharmacy Plus encourages states to use a three-tier system of co-payments. Cost sharing models used in Pharmacy Plus may be designed to protect people with most severe illnesses or disabilities by offering "stop-loss" protection against the cumulative impact of co-payments and deductibles

1. **X** The proposed program will include enrollee cost sharing (enrollment fees, premiums, co-payments, coinsurance, deductibles, etc.):

    a. **X** Enrollment fees will be required and are **$25 every enrollment period of 12 months. If the fees vary according to individual FPL, specify below (describe): The enrollment fee will be waived during the first year of implementation. The State plans to collect the enrollment fee prior to the second year of implementation, at the time of recertification . The State may waive the enrollment fee in the second year and thereafter if overall RIx + expenditures are below expected levels. GPA recipients enrolled in the Rx waiver will not be required to pay an enrollment fee as they meet the level of need for monthly cash assistance grants. The State plans to collect enrollment fees by utilizing the billing and premium collection systems established for the RIte Care Medicaid managed care program. The State has a contract for RIte Care premium billing services with the company that developed a similar system for Colorado's SCHIP program; a local financial institution manages premium collection using a lock-box to receive payments and electronic systems to record and transfer premium monies to the State. In short, the State has in place the infrastructure required for the collection of enrollment fees.**

b. _____ Premiums will be required:
    i. ____ Premiums are tiered or charged according to a sliding fee schedule that is ____ attached or ____described below:
    ii. ____ Premiums are fixed in the amount of $ _____ per person on a _____ monthly basis, _____ annual basis, or _____ other (described):
    iii. ____ Other (describe):

    c. **X** Co-payments and Coinsurance:
    i. in the amount of _____ per prescription or
    ii. **X** Beneficiaries will have different copayments for single source, branded multi source, and generic drugs, according to the following schedule (describe): **Co-pays for GPA-eligible enrollees will be waived as it is the State's general policy not to impose co-payment requirements on impoverished individuals, who are eligible for cash assistance – e.g., same policy applies to Medicaid population with income up to 100% of FPL and Section 1931**

families. However, the State is requesting the authority to charge GPA in the event that utilization and thus expenditures for GPA enrollees far exceed projections after year one of the waiver. CMAP –eligible enrollees will not be charged co-pays for the psychotropic prescription drug, they receive for free at present. State expenditures on these medications will also not count toward the $1,800 level I co-pay cap, as explained below.

iii. Brand name/ **no generic: $8** per prescription or ____ percent of the cost.
iv. Branded multi-source: **$20** per prescription or ____ percent of the cost.
v. Generic: **$2** per prescription or ____ percent of the cost.

These co-pays (level 1) apply until the State's share of the cost for prescriptions filled (i.e., excluding enrollee co-pays) reaches $1,800 in a given year; after $1,800 is reached, level 2 co-pays apply as follows: $25 branded-multi-source; $12 brand-name/no generic; and $4 generic. The State elected to use a two-level co-payment system to: (1) assist in maintaining costs; and (2) ensure enrollees are sensitive to utilization patterns. (For details on rationale for selecting $1,800 figure, SEE SUPPLEMENT.)

d. _____ Deductibles (describe):

e. **X** Cost sharing requirements will vary with utilization (i.e.,premiums, co-payments, and coinsurance)
   i. _____ Cost sharing amounts/requirements will decrease as individuals use more services (describe):
   ii. **X** _____ Cost sharing amounts/requirements will increase as individuals use more services (describe): **Co-pays will increase for seniors and CMPA-eligible enrollees once State's costs reach $1,800. See above and supplement for further details.**
   iii. _____ Other (describe):

2. _____ The proposed program will not include enrollee cost sharing that differs from that in the Medicaid State Plan

3. _____ The proposed program will include enrollee cost sharing stop-loss protections (describe):

4. _____ Other (describe):

K. The Demonstration Will Deliver Services in the Following Manner (check all that apply)

1. **X** _____ Services will be delivered through private health insurance coverage, but only to the extent that those with an other form of prescription drug coverage will receive wraparound services up to the waiver benefit level.

2. **X** Services will be delivered fee-for-service through this demonstration **as is current practice more generally for categorically and medically needy Medicaid recipients in the aged, blind and disabled population.**

3. _____ Services will be delivered through a system other than fee-for-service through this demonstration (describe):

4. _____ Services will be delivered through this demonstration using the same network of providers that deliver comparable services to Medicaid beneficiaries

5. _____ Services will be delivered through this demonstration using a subset of providers that deliver services to Medicaid beneficiaries

6. _____ Services will not be delivered by providers that serve Medicaid beneficiaries (describe how providers will be selected)

7. _____ Other (describe):

V. BUDGET NEUTRALITY

The federal costs of services provided during the demonstration will be no more than 100 percent of the expected costs of providing Medicaid services without the demonstration. A new population that would otherwise not be eligible for Medicaid will be able to obtain prescription drugs paid for by Medicaid. While the demonstration includes individuals who are not otherwise eligible for full Medicaid coverage, this new population could become eligible for full Medicaid coverage over the life of the demonstration through deterioration in their health status and reduced income due to high medical expenses. Federal payments will be provided for the Pharmacy Plus costs incurred for the demonstration population to the extent that federal Medicaid payments to the state do not exceed what would otherwise be paid.

The groups subject to budget neutrality - called the impacted population - are those expected to generate savings for the state because participants in Pharmacy Plus will incur less costs and remain healthier, thereby creating a delay in the need for full benefit Medicaid, in effect, a diversion from eligibility. While the expenditures for these groups are included in budget neutrality, the benefits of the existing Medicaid eligibility groups are not to be altered. Cutbacks in eligibility for existing Medicaid eligibility groups covered under the state's Medicaid Plan cannot be used as a source of savings for purposes of meeting budget neutrality. Savings that do not reduce benefits or limit eligibility but are achieved through better management of pharmacy services to existing Medicaid populations may be considered in the budget neutrality calculations.

The Terms and Conditions of Approval will specify that demonstrations must be in compliance with federal law and regulation related to sources and uses of Medicaid financing. In its budget neutrality calculations, the state should be able to demonstrate the impact of any recent changes to Medicaid law and regulation in its without-waiver and with-waiver calculations. For example, a state with an approved Upper Payment Limit plan, entitled to a transition period, under regulation, must demonstrate how the excess payments made under the UPL plan will be phased out during the waiver.

The Terms and Conditions of Approval will specify the aggregate financial ceiling for future expenditures for which federal financial participation (FFP) will be available. Under the aggregate ceiling methodology the state and federal authorities must reach agreement prior to demonstration approval on cost and eligibility trend rates. The trend rates will then be in place in the budget ceiling during the demonstration.

The attached budget shell relies upon a credible methodology that estimates a budget neutral program. When a Pharmacy Plus demonstration entirely or partially subsumes a state-only funded pharmacy program, the state must provide documentation as to how Medicaid expenditures will be reduced under the demonstration (compared to the "without demonstration" levels) and how budget neutrality will be achieved. The attached budget shell **X** was used in the development of the budget neutrality ceiling.

A. Impacted Budget Neutrality Population. Table V.1 identifies the Medicaid population groups that are included in the budget neutrality calculation (i.e., the impacted population).

Table V.1 (check all groups that apply):				
Population	All (1)	Institutionalized (2)	Community Dwelling (3)	Other (described): (4)
Aged	X			
Blind/Disabled Adults	X			
Blind/Disabled non-Adults				

B. Costs. The state estimates the services cost of this program will be $**276,511,123** over its **5** year demonstration period.

VI. EXPENDITURE AUTHORITY

The Following Authority is Needed for this Demonstration Under Costs not Otherwise Matchable (item is checked to verify the request):

A. **X** Section 1115(a)(1) authority of the Social Security Act is requested to enable the state to restrict freedom of choice of provider through a method such as pharmacy benefit management.

B. **X** Section 1115(a)(2) authority of the Social Security Act is requested for the following expenditures to be made under the **Rhode Island RIx +** demonstration (which are not otherwise included as expenditures under section 1903) for the period of the demonstration to be regarded as expenditures under the Title XIX program.

> Expenditures for extending pharmacy benefits and **primary care and pharmacy/therapeutic drug managementfor Medicare beneficiaries and seniors 65 and older; individuals with chronic mental health age 19 and over and impoverished individuals with chronic and disabling conditions age 19 up to age 65** at or below **200%** percent of the federal poverty level (FPL) who are Medicare eligible, or people with a disability, who are not otherwise Medicaid eligible under the state plan except for Medicaid coverage of Medicare premiums or cost sharing.

In addition, the following will not be applicable in this demonstration:

- *Premiums and Cost Sharing under Section 1916*: To permit fixed premiums, and cost sharing that is more than nominal, to be imposed on and collected from demonstration participants.

- *Amount Duration and Scope of Services under Section 1902(a)(1O)(B):* To permit the state to offer demonstration participants benefits that are not equal in amount, duration and scope to other Medicaid beneficiaries.

- *Retroactive Eligibility under Section 1902(a)(34):* To permit the state not to offer demonstration participants retroactive eligibility.

- *Premiums under Section 1902(a)(14):* To permit the state to impose on and collect premiums from demonstration participants in excess of those that would be permitted under section 1916.

VII. EVALUATION

The purpose of Pharmacy Plus is to expand coverage of a prescription drug benefit to low-income seniors and Medicare beneficiaries with disabilities and, by so doing, to divert or defer entry by these individuals into the Medicaid program. Budget neutrality is a feature of these demonstrations and is designed to track the overall cost and savings of the program. However, it is important to evaluate these demonstrations in other than budgetary terms. To understand how effective the program is for individuals, provide a description below of the state context of the program, the goals for the program, and how the program's success will be evaluated. In addition, CMS intends to conduct an independent evaluation of several of the Pharmacy Plus demonstration projects.

Included as an Attachment to the Application are the following:

A. X Current State Context. Provide an assessment of the current pharmacy coverage status of individuals in the state which includes summary information of individuals whose incomes are at or below 200 percent FPL who:

1. X do not have private insurance or other coverage of pharmaceuticals
2. X have private insurance that covers pharmaceuticals
3. X are in the state only funded pharmacy program

B. X The state's goal for increasing pharmacy coverage to the population targeted by the demonstration, including:

1. X the state's demonstration hypothesis
2. X the state's execution of the hypotheses via the demonstration project operation

VIII. ADDITIONAL REQUIREMENTS

In addition to the above requirements, the state agrees to the Pharmacy Plus Model Special Terms and Conditions (STCs) of Approval, and agrees to prepare the Operational Protocol document as described in the Model STCs. During CMS's review and consideration of this demonstration request, using the Model STCs, we will work with CMS to develop STCs that are specific to this request that would become part of the approval of demonstration authority.

This demonstration proposal is submitted to CMS on **10-21-02**

10-21-02 **Jane A. Hayward, Director of RI Department of Human Services**
Date Name of Authorizing Official, Typed

_____
Name of Authorizing Official, Signed

PHARMACY PLUS

A DEMONSTRATION PROGRAM UNDER SECTION 1115

Public Notice

Provide a description of the public notice process for Pharmacy Plus, including varying activities and stakeholder groups included in each:

Legislation enacted in July 2002 directed the RI Department of Human Services to develop a Pharmacy Plus waiver proposal in conjunction with the RI Department of Elderly Affairs. Over the course of the summer of 2002, both agencies and the RI Department of Mental Health, Retardation and Hospitals met weekly to discuss the scope of the waiver proposal. Public notice of these efforts proceeded as follows:

August 2002.

- CAC Meeting -- A preliminary draft of the waiver proposal was the subject of public meeting held on August 30, 2002 at the main branch of the Warwick Public Library, which is centrally located in the largest city in the State. Members of the State's Medicaid Consumer Advisory Council (CAC) were mailed invitations to attend the meeting; in addition, notice of the meeting was also posted at various locations across the State. A list of the membership of the Consumer Advisory Council is attached. Attendees were presented with an overview of the waiver proposal and encouraged to ask questions/make comment. Approximately 40 people attended the meeting.

September 2002.

- Roundtable Discussions -- During the first two weeks of September, staff of the DEA and DHS held roundtable discussions about the details of the waiver proposal with various concerned citizens, CAC members, and advocates who attended the August CAC meeting. Representatives of groups advocating for the elderly and individuals with disabilities were also provided with written materials about the waiver proposal to disseminate to members.

- CAC Meeting – A second open CAC meeting, held on September 30, 2002, was well-attended by representatives of elderly and mentally ill community as well as by advocates for persons with disabilities. Materials summarizing the key points of the waiver were distributed for review and comment.

October 2002.

- Public Notice/Hearings -- A public notice of the State's intent to submit a waiver proposal and hold hearings prior to implementation, if the waiver is approved by CMS, will be published on October 25, 2002 in ***The Providence Journal*** (see notice attached to supplement) and posted on the DHS website.

  The notice includes planned date of proposed waiver submission, information about where to obtain copies, and schedule for hearings.

Post CMS Waiver Approval

- Administrative-Rule-making --DHS is required by law to seek approval for implementation about the waiver to the RI Health Care Legislative Oversight Committee in a public hearing if the waiver is approved. Date and time of the Committee hearing must be posted in accordance with the State's public information –open meetings law.

- Rules governing the operations of the RIx + waiver program, if approved, will be adopted in accordance with the State's Administrative Procedures Act (APA). The APA process has rigorous public notice, information, and comment requirements as well provisions for public hearings.

PHARMACY PLUS

A DEMONSTRATION PROGRAM UNDER SECTION 1115

Attachment 2

DEFINITIONS

Budget Neutrality –The policy for Section 1115 demonstrations under which the state does not receive more in federal title XIX matching funds under the demonstration than it would have received without it.

Budget Neutrality Ceiling –An expenditure limit, negotiated between the state and CMS, placed on the amount of FFP available to a state under the demonstration. The expenditure limit for Pharmacy Plus waivers is calculated using the aggregate method. The aggregate expenditure limit is calculated as a fixed amount that does not vary based upon enrollment changes in the state.

Private Health Insurance - Group health plan coverage and health insurance coverage as defined in section 2791 of the Public Health Services Act.

Expansion population - Individuals eligible for benefits under the state Pharmacy Plus demonstration program who are not enrolled in the regular Medicaid program.

Full Medicaid benefit – The Medicaid benefit package available to individuals who are eligible for Medicaid without the Pharmacy Plus waiver.

Impacted population - The Medicaid eligibility group or groups whose Medicaid costs are included in the budget neutrality cap. Under Pharmacy Plus, the state is expected to achieve savings from this group because of the diversion from the regular Medicaid program of a proportion of the expansion population.

Enrollee Cost Sharing – Premium charges, enrollment fees, deductibles, coinsurance, co-payments or other similar fees that the Pharmacy Plus enrollee is responsable for paying. Cost sharing for Pharmacy Plus enrollees can deviate from requirements in Medicaid and can be used to reduce program costs by requiring participant payments, encouraging the use of non-brand drugs, and can vary to moderate out of pocket burdens for high utilizers.

Enrollment Ceiling -- A number limit on demonstration program enrollment. States may use an enrollment ceiling to limit the numbers of individuals enrolled in the demonstration so that financial risk for demonstration costs is minimized. States may not enact an enrollment ceiling for the non-demonstration Medicaid program.

Drug Rebates - The quarterly payments made by the pharmaceutical manufacturer to the state Medicaid agency, as calculated in accordance with section 1927 of the Social Security Act and the provisions of the agreement between the manufacturer and the Secretary. States can receive rebates for pharmaceutical products in Pharmacy Plus as long as a state payment is made for the drug and there is not a formulary that does not conform to the provisions of 1927(d)(4) of the Act.

Wraparound Coverage - Pharmacy Plus coverage of services not covered under a beneficiary's private health insurance. Examples of wraparound coverage include a Pharmacy Plus program paying for drugs not covered by private insurance, a Pharmacy Plus program covering an amount of drugs in excess of that covered by private insurance (for example, if the private insurance coverage includes three prescriptions per month, Pharmacy Plus could pay for additional prescriptions); and Pharmacy Plus coverage when a private insurance financial benefit is exceeded.

Terms and Conditions of Approval - A document produced by CMS which provides conditions which states must follow in order to receive approval of their Pharmacy Plus waiver.

Operational Protocol - A stand-alone document that reflects the operating policies and administrative guidelines of the Pharmacy Plus waiver.

Prior Authorization – Requiring approval of the drug before it is dispensed for any medically accepted indication as defined in 1927(k)(6) of the Act.

Formulary or Formulary Exclusions - A list of prescription drugs developed in accordance with 1927(d)(4) of the Social Security Act. At state option, the formulary provisions for the expansion population may differ from 1927(d)(4) as delineated by the template allowance of coverage of condition-specific drugs or limited sets of drugs (see template).